Revision: HCFA-PM-86-20 (BERC)

SEPTEMBER 1986

ATTACHMENT 3.1-B

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OMB No. 0938-0193

State/Territory: _ILLINGIS

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY WEEDY GROUP(S): All - Specified in Item C of Attachment 2.2-A

The following ambulatory services are provided.

- .Hospital outpatient and emergency room visits
- .Clinic, including Rural health
- .Physician
- .Podiatric
- .Chiropractic
- Other practitioners (psychiatrist; speech, occupational, physical therapists; and registered nurses)
- .Home Health Agencies
- .Prescribed Drugs
- .Dentures, eyeglasses, prosthetic devices
- .Durable medical equipment and supplies
- .Laboratory and x-ray
- . RPSDT
- .Transportation

.Dental

*Description provided on attachment.

TN No. 90-4 Supersedes TH No. 87-4

Approval Date

Effective Date 1-1-90

HCFA ID: 0140P/0102A

Revision:	HCFA-PM-91- AUGUST 1991	4 (BPI)	ATTACHMENT 3.1-8 Page 2 OMB No. 0938-
	State/Territ	:ory:	ILLINOIS	
	AMOUNT, MEDICALL	DURATION Y NEEDY C	ROUP(S):	E OF SERVICES PROVIDED
l. Inpat insti	ient hospital tution for me	service	s other tha	n those provided in an
	Provided:	<u>∠</u> /No 1	imitations	A/With limitations.
2.a.Outpat	ient hospita	l service	s .	
<u> </u>	Provided:	∠/No 1	imitations	Z/With limitations.
b.Rural furni:	health clinic shed by a rur	: service	s and other clinic.	ambulatory services
<u> </u>	Provided:	∠/No 1	imitations	A/With limitations*
3. Other	laboratory an	d X-ray	services.	•
. 27	Provided:	∠/ No	limitation	s ZWith limitations*
.a.Nursind mental	g facility se L diseases) f	rvices (cor indivi	other than duals 21 ye	services in an institution for pars of age or older.
∠ \$\overline{\pi}\$1	Provided:	_/No limi	itations 🛭	With limitations.
b.Early a indivi	and periodic duals under	screening 21 years	, diagnost. of age, and	ic and treatment services for itreatment of conditions found.
c.Family childb	planning ser	vices and	i supplies	for individuals of
<u>AZ/8</u>	Provided: 💪	No limit	ations	With limitations*
	on provided o	n attachs	ent.	
N No. 9		l Date	7-28-94	Effective Date 4-1-93
N No. 91		_		HCFA ID: 7986E
ambu an F	latory servi	ces that dance wit	TLE COAGLE	PONC) services and other d under the plan and furnished by 6231 of the State Medicaid Manual
	Provided: ations for pa			ons** / With limitations thy Moms/Healthy Kids are defined in

the Appendix.

MAY 1993 OMB NO: State/Territory: ILLINOIS AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(s): 5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere. ___ No limitations X With limitations* b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act). ___ No limitations X With limitations: *Description provided on attachment. No.

Approval Date 10-12-93 Effective Date 7-1-93

ATTACHMENT 3.1-B

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	State/Terr	itory:	ILLINOIS			
	AMOUI HEDICA	IT, DURAT	TION AND SCOPE OF GROUP(S): All	- Spe	ICES PROVIDED ecified in Item C of Attachme	ent 2.2-A
6.		by lice	nsed practitione		care recognized under State hin the scope of their	
٠.	Podiatrists' S	ervices			Asr	
	/X/ Provided:	乊	No limitations	<u> </u>	With limitations*	CIAI
b.	Optometrists'	Services	•	•		MI
	/X/ Provided:	<u>~</u>	No limitations	<u>K</u> /	With limitations*	
c.	Chiropractors'	Services	•		•	
	Z/ Provided:	乊	No limitations	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	With limitations*	
đ.	Other Practiti	oners' S	ervices	•		
	<pre>Provided:</pre>		No limitations	乊	With limitations*	
7.	Home Health Se	rvices				
٠.					ovided by a home health health agency exists in	
	<u>√</u> X Provided:		No limitations	<u>X</u>	With limitations*	
ъ.	Home health ai	de servi	es provided by	a home	health agency.	
	/X/ Provided:		No limitations	<u>~</u>	With limitations*	
c.	Medical supplications.	es, equi;	ement, and application	ances i	suitable for use in the	
	<u>√X</u> / Provided:	<u> </u>	No limitations	X7	With limitations*	
đ.		ices prov	rided by a home !		peech pathology and agency or medical	
	<u></u>	乙	No limitations	<u> </u>	With limitations*	
*Descr	iption provided	on attac	hment.			
TN No.	90-4		-//			
Supers IN No.	87-4	Approva	1 Date 5/1/9		Effective Date 1-1-90	

HCFA ID: 0140P/0102A

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OFFICIAL

ATTACHMENT 3.1-8 Page 4 ONB No. 0938-0193

State/Territory: _ILI

ILLINOIS

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

HEDICALLY WEEDY GROUP(S): All - Specified in Item C of Attachment 2.2-A

В.	Priv	ate duty nu	raing :	services.		•
	₩	Provided:	乊	So limitation	us $\sqrt{\chi_f}$	With limitations*
9.	Clin	ic services	•			
	<u> </u>	Provided:	Ū	No limitation	1 <u>X</u> /	With limitations*
10.	Dent	al services	•			
	¥	Provided:	7	No limitation	u I	Vith limitations*
11.	Phys	ical therap	y and a	related service	. .	
8.	Phys.	ical therap	y .			
	<u>√X</u> /	Próvided:	卫	So limitation		With limitations*
b .	Occup	pational th	огвру.			
	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Provided:	ヹ	No limitation		With limitations*
						g, and language disorders pathologist or sudiologist.
	<u> </u>	Provided:	Ū	So limitation		With limitations*
12.	pres					evices; and eyeglasses s of the eye or by an
٠.	Pres	cribed drug	s.			
	7	Provided:	口	No limitation		With limitations*
ъ.	Dent	ures.				%
	X/	Provided:	7	We limitation	s <u>K</u> /	With limitations*
*Desci	iptio	provided	on att	schment.		
TH No. Superi	91- •des 88-1	2	Approv	val Date 4-2	6-91	Effective Date 1-1-91

HCFA ID: 0140P/0102A



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	2-2-A ·
c.	Prosthetic devices.
	Provided: // Wo limitations /X/ With limitations*
d.	Eyeglasses.
	/ Provided: // Bo limitations /X/ With limitations*
13.	Other disgnostic, screening, preventive, and rehabilitative services i.e., other than those provided elsewhere in this plan.
٠.	Diagnostic services.
	N/ Provided: N/ No limitations //. With limitations*
b.	Screening services.
	/K/ Provided: // No limitations /K/ With limitations*
c.	Preventive services.
	/W Provided: // No limitations X/ With limitations*
đ.	Rehabilitative services.
	/ Provided: // Wo limitations X/ With limitations*
14.	Services for individuals age 65 or older in institutions for mental diseases.
٠.	Impatient hospital services.
	Provided: No limitations With limitations*
ъ.	Skilled nursing facility services.
Descr	/X/ Provided: // No limitations /X/ With limitations iption provided on attachment.

REVISION: HCFA-PM-86-20 (BERC)

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ATTACHMENT 3.1-B Page 6 QMB NO. 0938-0193

TN No:		Approval Date MAR 2 2	Effective Date 10-26-95
*Descr	iption provided as a	attachment.	e 3
	•	· · · · · · · · · · · · · · · · · · ·	
	Not Provided		
	x Provided:	No limitations	K With limitations
18.	Hospice care (in a	accordance with section	1903(a) of the Act).
	X Provided:	No limitations	X With limitations
17.	Nurse-midwife serv	ices.	
	X Provided:	No limitations	X With limitations
16.	Inpatient psychiat of age.	ric facility services for	or individuals under 22 years
	X Provided:	No limitations	X With limitations
b.	Including such ser thereof) for the m	vices is a public institentable retarded or pers	tution (or distinct part sons with related conditions.
	X Provided:	No limitations	X With limitations
15. a.	institution for me	ntal diseases) for perso	r than such services in an ons determined in accordance o be in need of such care.
	X Provided:	No limitations	X With limitations
a.	Intermediate care	facility services.	
	AMOUNT, DU	RATION AND SCOPE OF SERV Y GROUP(S): <u>All - Speci</u> Atta	Ified in Item C of achment 2.2
	State/Territory:	Illinois	

TN No: <u>95-</u>15

HCFA ID: 0140P/0102P

		State/Territory: Illinois
		AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S): All - specified in Item C of Attachment 2.2-A
19.	Case man	agement services and Tuberculosis related services
	4.	Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT $3.1-A$ (in accordance with section 1905(a)(19) or section 1915(g) of the Act).
		X. Provided:X With limitations*
	_	Not provided.
	b.	Special tuberculosis (TB) related services under section $1902(z)(2)(F)$ of the Act.
		Provided: With limitations*
	_ x	Not provided.
2C.	Extended	services for pregnant women.
	4.	Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.
	<u>x</u>	Provided: X Additional coverage
	b.	Services for any other medical conditions that may complicate pregnancy.
	×	Provided: Additional coverage Not provided.
21.	Certifie	d pediatric or family nurse practitioners' services.
	x	Provided: No limitations <u>x</u> With limitations*
		Not provided.
	•	Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.
	**	Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.
•Desc	ription p	provided on attachment.
TN No	. 96-	16
Super	sedes of	-20 Approval Date 50 6 1898 Effective Date 7-1-96
IN No	. ,,,	4V



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		State/Terri	tory:	ILLINOIS		
		AHOUNT, MEDICALL	DURA'	TION, AND SCOPE (DY GROUP(S): A	OF SERV	ICES PROVIDED
22.	Resp	iratory care ugh (C) of t	servi	ices (in accordar i).	nce wit	h section 1902(e)(9)(A)
	<u>(X</u> /	Provided:	乙	No limitations	<u> </u>	With limitations*
	D.	Wot provided				
23.	Any unde	other medica r State law,	l care speci	and any other tified by the Secr	ype of retary.	remedial care recognized
8	. Trans	sportation.				
	K/	Provided:	7	So limitations	W	With limitations*
)	Sorv	ices of Chri	stian	Science nurses.		
	(X)	Provided:	乙	So limitations	X)	Vith limitations*
e.	. Care	and service	s btos	ided in Christia	n Seien	ce sanitoria.
	<u> </u>	Provided:	Ū	So limitations	J	With limitations*
4.	skill of a	led nursing :	facili	ty services prov	ided fo	r patients under 21 years
	K/	Provided:	迈	So limitations	<u> </u>	With limitations*
•.	. Emer	sency bospit	el ser	vices.		
	Ū	Provided:	Ū	So limitations	乊	With limitations*
*		e estage in estage				er de la estada del estada de la estada del estada de la estada del estada de la es
€.	with		restae	nt and furnished		rescribed in accordance unlifted person under
		Sand dad.	,7	No limitations	177	With limitations*

Revision: HCFA-PM-94-9 (MB) ATTACHMENT 3.1-B DECEMBER 1994 Page 9 State/Territory: <u>ILLINOIS</u> AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S): All - specified in Item C of Attachment 2.2-A Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and 24. Appendices A-G to Supplement 2 to Attachment 3.1-A. Provided X Not Provided 25. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home. Provided: ___ State Approved (Not Physician) Service Plan Allowed Services Outside the Home Also Allowed Limitations Described on Attachment X Not provided.

No. 96-1 Supersedes Approval Date 4-5-96 Effective Date 01-01-96

N No. ___93-2

TN